205.6315 Requirements when private peer review organization is contracted with to conduct reviews of levels of care.

When the cabinet contracts with any private peer review organization to conduct utilization reviews of the levels of care of the state's Medicaid program recipients, the following shall apply:

(1) In determining the appropriate level of care of a Medicaid beneficiary who is a patient in a nursing facility setting, and prior to any change that reduces a Medicaid beneficiary's eligibility for covered services, the contracted peer review organization shall assure that:

(a) An in-person assessment of the Medicaid beneficiary is made; and

(b) A licensed physician has reviewed the written documentation of the peer review organization's evaluation and provided a written review of the evaluation to be a part of the patient's record.

(2) If the level of care is changed for a Medicaid beneficiary who is a resident or patient in a nursing facility setting or a Medicaid beneficiary who receives community-based waiver services, and the change makes that beneficiary ineligible for the Medicaid covered service, the peer review organization shall notify the commissioner of Medicaid in the cabinet, and shall provide a written notification sent by registered return receipt mail to the affected Medicaid beneficiary, nursing facility, affected Medicaid beneficiary's attending physician, and the affected beneficiary's responsible party.

(3) If the level of care for a Medicaid beneficiary results in an adverse determination, the affected Medicaid beneficiary, or the responsible person or party, may appeal through an application for reconsideration to be filed with the cabinet within ten (10) days from the date of receipt of the registered return receipt written notification. If the responsible party's registered return receipt mail is undeliverable, the attending physician may initiate the appeal on behalf of the affected Medicaid beneficiary.

(a) All benefits which the affected Medicaid recipient, and the nursing facility are eligible for shall be continued during that ten (10) day time frame; and

(b) As long as the affected Medicaid recipient is engaged in an appeal of an adverse determination from a peer review organization, all benefits for which the affected Medicaid recipient and nursing facility are eligible shall be continued until an appropriate residential setting is secured, in any event, not to exceed ninety (90) days from the date of the request for a hearing, or until a final determination is made by a hearing officer.

(4) (a) If the level of care is lowered for a Medicaid beneficiary who is a resident or patient in a nursing facility setting, an independent examination may be conducted by the resident's attending physician.

(b) If the resident's attending physician conducts an independent examination, the attending physician shall make a recommendation concerning the appropriate level of care and forward, in writing, the results of the examination and the

recommendation to the peer review organization, the affected recipient, the nursing facility, and the responsible party.

(5) For the purposes of this section, "responsible person or party" shall mean an individual authorized by the resident of the facility to act for the resident as an official delegate or agent. The responsible person may be a guardian, payee, family member, or any other individual who has arranged for the care of the resident and assumed this responsibility. The responsible party may or may not be related to the resident. A responsible person or party is not a guardian unless so appointed by the court.

(6) The peer review organization shall:

(a) Inform the patient and guardian, responsible party, or family member, upon initial qualification for Medicaid covered services, and with the written notification of an adverse determination from a peer review organization:

1. Of the manner in which notification of any adverse decision will be made;
2. Of the process for securing a timely review of any adverse decision;
3. That a request for reconsideration must be postmarked no later than ten (10) days after receipt of the initial written notification of any adverse decision;
4. Of the toll-free line that will be provided for questions regarding reviews; and
5. Of the process for appealing an adverse reconsideration to the cabinet;

(b) Provide a written peer review organization physician review of all adverse determinations;

(c) Provide for an attending physician review of all adverse determinations as outlined in subsection (4) of this section;

(d) Inform the commissioner of all information related to an appeal of an adverse action; and

(e) Provide the information identified in paragraph (a) of this subsection, at the time of an adverse determination notification, to any affected nursing facility in which a Medicaid beneficiary resides.

Effective: July 15, 1998

History: Created 1998 Ky. Acts ch. 205, sec. 1, effective July 15, 1998.